

06127

Reg. Dist. No.

VS A15 (4)  
15M 10/57

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rumbley</b>		c. LENGTH OF STAY IN 1b <b>31 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rumbley</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLIFFORD</b>		Middle <b>COLLINS</b>		Last <b>DIZE</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH <b>May 3,</b>		9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Contracting</b>		13. BIRTHPLACE (State or foreign country) <b>Rumbley, Maryland</b>	
14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. FATHER'S NAME <b>George E. Dize</b>		16. MOTHER'S MAIDEN NAME <b>Hutchie Tyler</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>212-14-4708</b>		19. INFORMANT <b>Mrs. Ella M. Dize, Rumbley, Md.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with generalized metastasis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
22a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		22b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town)</b> (County) (State)	
23. I certify that I attended the deceased from <b>June 3</b> , 19 <b>58</b> , to <b>May 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>58</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b>		DATE SIGNED <b>5-4-58</b>	
ACTUAL SIGNATURE <b>Everett C. Sutter</b>		M.D. <b>Dames Quarter, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter</b>		ADDRESS <b>Dames Quarter, Md.</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE THEREOF <b>May 6, 1958</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mechanics Cemetery</b>	
24d. LOCATION (City, town, or county) <b>Fairmount, Md.</b>		(State) <b>(State)</b>			
25. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		26. REC'D. BY REGISTRAR <b>MAY 8 58</b>	
27. REGISTRAR'S SIGNATURE <b>W. H. Sutter</b>		DATE <b>MAY 8 58</b>			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6145 CERTIFICATE OF DEATH

06128

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Vernon</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Vernon</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD</b>		d. STREET ADDRESS <b>RFD</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T.</b> Last <b>DONALDS</b>		4. DATE OF DEATH Month <b>May 10,</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm (not own)</b>	
11. BIRTHPLACE (State or foreign country) <b>Chance, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Oscar Donalds</b>		14. MOTHER'S MAIDEN NAME <b>Cora Mister</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ina Collins, Mt. Vernon, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>11 months 6 days</b> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-22-57</b> , 19 <b>57</b> , to <b>5-10-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-10-58</b> , 19 <b>58</b> , and that death occurred at <b>4P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>5-12-58</b>			
ACTUAL SIGNATURE <b>Everett C. Sutter, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Everett C. Sutter, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 12, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chance Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Chance, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw, Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAY 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Lewis</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6137 CERTIFICATE OF DEATH

Reg. Dist. No. 06129

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>50 YS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PRINCETON JENNEFER DOUGLAS</b>		4. DATE OF DEATH <b>MAY 3 19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 7, 1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL DOUGLAS</b>		14. MOTHER'S MAIDEN NAME <b>CORA SUTTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>213-10-7266</b>	
17. INFORMANT <b>JOHN BOWMAN, 203 S. SEVENTH ST.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>53 hours</b> Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-31</b> , 19 <b>53</b> , to <b>5-3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 2</b> , 19 <b>58</b> , and that death occurred at <b>6:48 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>DR. A. N. BARR.</b>		DATE SIGNED <b>5/3/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 7-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LAWSON</b>	22d. LOCATION (City, town, or county) (State) <b>CRISFIELD, SOM. CO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Howard Marion Sta MD</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAY 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6188 CERTIFICATE OF DEATH

Reg. Dist. No.

06130

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DOA McCreedy Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>MAE</b> Last <b>FORD</b>		4. DATE OF DEATH Month <b>May 6,</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR: Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min. <b>84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raleigh Parks</b>		14. MOTHER'S MAIDEN NAME <b>Aurelia Lawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Chas. F. Smith, 109 Richardson, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO <b>Hypertension Arteriosclerotic Cardio-</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Vascular Disease</b> DUE TO (c) <b>Known</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Similar</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 23, 1958</b> to <b>May 6, 1958</b> , that I last saw the deceased alive on <b>May 6, 1958</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		DATE SIGNED <b>5/8/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAY 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Decedent's Name [Name]		Date of Birth [Date]		Sex [Sex]	
Race [Race]		Marital Status [Status]		Date of Death [Date]	
Place of Birth [Place]		Usual Residence [Address]		Cause of Death [Cause]	
Occupation [Occupation]		Date of Death [Date]		Place of Death [Place]	
Signature of Physician [Signature]		Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	
Date of Signature [Date]		Date of Signature [Date]		Date of Signature [Date]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6146

CERTIFICATE OF DEATH

06131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne, Md.</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Princess Anne, Md.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>James</b> Last <b>Hall Jr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 18, 1898</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Tax Assessor, Somerset Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward James Hall Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ella Noble</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-32-1017</b>		17. INFORMANT <b>E.C. Sutter M.D.</b> Address <b>Dames Quarter, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-9-57</b> , 19____, to <b>May 18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 18</b> , 19 <b>58</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>5-18-58</b>							
ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D.				PHYSICIAN'S NAME (Type) <b>Everett C. Sutter M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oriole, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Hannon</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hannon</b>			

CERTIFICATE OF DEATH

Name of Deceased Mary, Elizabeth, nee, ...		Date of Birth ...	
Sex Female		Race White	
Date of Death ...		Place of Death ...	
Cause of Death ...		Manner of Death ...	
Physician's Signature ...		Registrar's Signature ...	
Date of Report ...		Report Made by ...	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3139

## CERTIFICATE OF DEATH

06132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCreedy Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>-</b> Last <b>HORSEY</b>		4. DATE OF DEATH Month <b>May 19,</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1882</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months <b>76</b>	11. IF UNDER 24 HRS. Days <b>76</b> Hours <b>76</b> Min. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>West Horsey</b>		14. MOTHER'S MAIDEN NAME <b>Gustina ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wells Horsey, Broadway, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x Hemorrhage, cerebral</b> DUE TO (b) <b>8 hrs</b> DUE TO (c) <b>8 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-19</b> , 19 <b>58</b> , to <b>5-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-19</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.		ADDRESS (Street, city or town, state) <b>Crisfield Md.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M. D.</b>		<b>Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 22, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw, Crisfield, Md.</b>		ADDRESS	
24a. REC'D <b>MAY 21 1958</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1900		St. Louis, Mo.	
Cause of Death		Disease		Symptoms		Duration		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		2 weeks		St. Louis, Mo.	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



Arkansas State Department of Health - Bureau of Vital Statistics  
This certificate is to be filed in the office of the Registrar of Births and Deaths, State of Arkansas, at the place of death of the deceased.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06133

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MANOKIN</b>			c. LENGTH OF STAY IN 1b <b>MANOKIN</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. STREET ADDRESS <b>1</b>		
3. NAME OF DECEASED (Type or print) <b>MAGGIE</b> First <b>MADDOX</b> Middle Last			4. DATE OF DEATH <b>MAY 28 1958</b> Month Day Year		
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>COL</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1870</b>	9. AGE (In years last birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>11 22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		
11. BIRTHPLACE (State or foreign country) <b>MANOKIN, SOM, MD</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13. FATHER'S NAME <b>JOHN WARD</b>			14. MOTHER'S MAIDEN NAME <b>HARITT TUIPIN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>ISAC T. MADDOX, MANOKIN, MD</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>chronic myocarditis</b> (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis / Hypertension</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>Year</b> <b>Year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>R. H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 31-58</b>	
EXAMINER'S NAME (Type) <b>R. H. Johnson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BUR</b>	22b. DATE THEREOF <b>JUN-1-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SAMUEL WESLEY</b>	22d. LOCATION (City, town, or county) (State) <b>MANOKIN, SOM, MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Howard</b>		ADDRESS <b>Marion Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>



20M673ET

MD  
MANOKIN

20M673ET

MANOKIN

WABOX MAY 28 28

Female 1870 87 11 28

MANOKIN, SCW, MD, USA

HARIT TURPIN

ISAC T WABOX, MANOKIN

MAGGIE

FEW CO

DOMESTIC

JOHN WARD

MANOKIN, SCW, MD

## 6140 CERTIFICATE OF DEATH

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>SHELLTOWN</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH JANE MCDANIEL</b>		4. DATE OF DEATH Month Day Year <b>MAY 29 1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1876</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE RIGGIN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MATTHEWS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>EUNICE MEARS, CRISFIELD, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Pulmonary Infarction - with</b> <b>443X</b> DUE TO <b>Arteriosclerosis - pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocarditis, nephritis - Hypertension</b> (c) <b>years -</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 29, 1958</b> , to <b>May 29, 1958</b> , that I last saw the deceased alive on <b>May 29, 1958</b> , and that death occurred at <b>6:30 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>George C. Coulbourn M.D.</b> <b>MARION STATION, MARYLAND</b>					
ACTUAL SIGNATURE <b>George C. Coulbourn M.D.</b>		PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, MARION STATION, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw, Crisfield, Maryland</b>		ADDRESS <b>H. Harvey Bradshaw, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 19

1911

NAME

AGE

SEX

RESIDENCE

DATE

PLACE OF DEATH

TIME

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE

PLACE

NAME

RELATIONSHIP

AGE

SEX

RESIDENCE

DATE

PLACE

TIME

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE

PLACE

TIME

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE

PLACE

TIME

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

1  
Item 8, 225 Film G229, 5/16/58 fcy  
6141  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

06135

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>-</b> Last <b>MURRAY</b>		4. DATE OF DEATH <b>May 3,</b> 1958	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Whitestone, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Horace Murray</b>		14. MOTHER'S MAIDEN NAME <b>Wilhemina Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 219-01-0699</b>	
17. INFORMANT <b>Fanny Murray, 9th St., Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arterio-sclerotic</b> DUE TO (c) <b>heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1947</b> to <b>1958</b> that I last saw the deceased alive on <b>Mar. 13, 1958</b> , and that death occurred at <b>3:30</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M. D.</b>		<b>Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 7, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		ADDRESS	
24a. RECEIVED BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
John Doe		Male		40 years		1950-1-15	
5. Place of death		6. Cause of death		7. Manner of death		8. Physician	
Home		Heart disease		Natural		Dr. J. Smith	
9. Burial place		10. Registrar		11. Signature		12. Date	
Cemetery		J. Doe		[Signature]		1950-1-15	
13. Remarks		14. Signature		15. Date		16. Signature	
[Text]		[Signature]		1950-1-15		[Signature]	
17. Signature		18. Date		19. Signature		20. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
21. Signature		22. Date		23. Signature		24. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
25. Signature		26. Date		27. Signature		28. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
29. Signature		30. Date		31. Signature		32. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
33. Signature		34. Date		35. Signature		36. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
37. Signature		38. Date		39. Signature		40. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
41. Signature		42. Date		43. Signature		44. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
45. Signature		46. Date		47. Signature		48. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
49. Signature		50. Date		51. Signature		52. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
53. Signature		54. Date		55. Signature		56. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
57. Signature		58. Date		59. Signature		60. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
61. Signature		62. Date		63. Signature		64. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
65. Signature		66. Date		67. Signature		68. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
69. Signature		70. Date		71. Signature		72. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
73. Signature		74. Date		75. Signature		76. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
77. Signature		78. Date		79. Signature		80. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
81. Signature		82. Date		83. Signature		84. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
85. Signature		86. Date		87. Signature		88. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
89. Signature		90. Date		91. Signature		92. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
93. Signature		94. Date		95. Signature		96. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	
97. Signature		98. Date		99. Signature		100. Date	
[Signature]		1950-1-15		[Signature]		1950-1-15	

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## 6148 CERTIFICATE OF DEATH

Reg. Dist. No. 06138

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Venton</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Reese</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>58</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1878</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Henry Causey</b>			14. MOTHER'S MAIDEN NAME <b>Mateldia Renshaw</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>E.C. Sutter M.D.</b> Address <b>Dames Quarter, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-22-58</b> , 19____, to <b>5-15-58</b> , 19____, that I last saw the deceased alive on <b>5-15-58</b> , 19____, and that death occurred at <b>11a M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D.				ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b>		DATE SIGNED <b>5-18-58</b>	
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) <b>Mt. Vernon, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Hanigan</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Reed</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME JAMES HANLEY, JR.		SEX Male		AGE 34 years	
RACE White		BIRTH DATE 10-10-1924		PLACE Baltimore, Md.	
OCCUPATION None		CAUSE Myocardial Infarction		MANNER Natural	
DATE OF DEATH 10-10-1958		TIME OF DEATH 11:00 AM		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JUDGE (None)	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be furnished to the local health officer of the city or county in which the death occurred.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6142

## CERTIFICATE OF DEATH

Reg. Dist. No. 06137

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Troy Road		d. STREET ADDRESS 1 Troy Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ROY - STERLING		4. DATE OF DEATH Month May 13, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1882
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Tubman Sterling		14. MOTHER'S MAIDEN NAME Lillie Sterling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-5472A	
17. INFORMANT Address Mrs. Ida Sterling, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Coronary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status Epilepticus to Cyanosis DUE TO (c) Hemorrhagic Anteriorobscure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Emaciation, Senility		INTERVAL BETWEEN ONSET AND DEATH 3 hours Known 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21, 1958, to May 13, 1958, that I last saw the deceased alive on May 13, 1958, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. N. Barr, M.D.		ADDRESS (Street, city or town, state) Crisfield, Md.	
DATE SIGNED 5/14/58			
PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1958	
22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Harvey Bradshaw, Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 16 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Physician		Hospital		Burial Place	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Place of Certificate		Official Seal	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6149 CERTIFICATE OF DEATH

Reg. Dist. No. 06138

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>				c. LENGTH OF STAY IN 1b <b>67 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>RFD #2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HESTER</b> Middle <b>STEVENSON</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/8/1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>							
13. FATHER'S NAME <b>LETTON ADAMS</b>				14. MOTHER'S MAIDEN NAME <b>SUSIE ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-16-7268</b>			
17. INFORMANT <b>SHERMAN STEVENSON PRINCESS ANNE MD RT #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 252.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Thyroidosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>5 yrs</b> <b>8 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>May 5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 5</b> , 19 <b>58</b> , and that death occurred at <b>1:03 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b> M.D.				ADDRESS (Street, city or town, state) <b>20 Prima William St. Princess Anne Md.</b>			
DATE SIGNED <b>May 6, 1958</b>							
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>COTTAGE GROVE</b>		22d. LOCATION (City, town, or county) (State) <b>GREEN HILL MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. James Jr. Princess Anne Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DATE MAY 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Q. Beach</b>							



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other disposition		20. Signature of other disposition	
21. Signature of other disposition		22. Signature of other disposition		23. Signature of other disposition		24. Signature of other disposition	
25. Signature of other disposition		26. Signature of other disposition		27. Signature of other disposition		28. Signature of other disposition	
29. Signature of other disposition		30. Signature of other disposition		31. Signature of other disposition		32. Signature of other disposition	
33. Signature of other disposition		34. Signature of other disposition		35. Signature of other disposition		36. Signature of other disposition	
37. Signature of other disposition		38. Signature of other disposition		39. Signature of other disposition		40. Signature of other disposition	
41. Signature of other disposition		42. Signature of other disposition		43. Signature of other disposition		44. Signature of other disposition	
45. Signature of other disposition		46. Signature of other disposition		47. Signature of other disposition		48. Signature of other disposition	
49. Signature of other disposition		50. Signature of other disposition		51. Signature of other disposition		52. Signature of other disposition	
53. Signature of other disposition		54. Signature of other disposition		55. Signature of other disposition		56. Signature of other disposition	
57. Signature of other disposition		58. Signature of other disposition		59. Signature of other disposition		60. Signature of other disposition	
61. Signature of other disposition		62. Signature of other disposition		63. Signature of other disposition		64. Signature of other disposition	
65. Signature of other disposition		66. Signature of other disposition		67. Signature of other disposition		68. Signature of other disposition	
69. Signature of other disposition		70. Signature of other disposition		71. Signature of other disposition		72. Signature of other disposition	
73. Signature of other disposition		74. Signature of other disposition		75. Signature of other disposition		76. Signature of other disposition	
77. Signature of other disposition		78. Signature of other disposition		79. Signature of other disposition		80. Signature of other disposition	
81. Signature of other disposition		82. Signature of other disposition		83. Signature of other disposition		84. Signature of other disposition	
85. Signature of other disposition		86. Signature of other disposition		87. Signature of other disposition		88. Signature of other disposition	
89. Signature of other disposition		90. Signature of other disposition		91. Signature of other disposition		92. Signature of other disposition	
93. Signature of other disposition		94. Signature of other disposition		95. Signature of other disposition		96. Signature of other disposition	
97. Signature of other disposition		98. Signature of other disposition		99. Signature of other disposition		100. Signature of other disposition	

Witnessed by: *James H. Jones*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6150 CERTIFICATE OF DEATH

Reg. Dist. No. 06134

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>				c. LENGTH OF STAY IN 1b <b>LIFE TIME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SIP</b> Middle <b>STEVENSON</b> Last				4. DATE OF DEATH Month <b>5</b> Day <b>15</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/9/1888</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A .</b>							
13. FATHER'S NAME <b>SMITH STEVENSON</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINA HARGIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>ADDIE STEVENSON PRINCESS ANNE MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Chronic myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchial Asthma</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 10<sup>th</sup></b> , 1958, to <b>May 15<sup>th</sup></b> , 1958, that I last saw the deceased alive on <b>May 12<sup>th</sup></b> , 1958, and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Eldon G. Markman M.D.</b> <b>Princess Anne, Md.</b> PHYSICIAN'S NAME (Type) <b>ELDON G. MARKMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. James</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE 14

1880

6143

## CERTIFICATE OF DEATH

Reg. Dist. No. 06140

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	c. LENGTH OF STAY IN 1b <b>Lifetime</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 E. Chesapeake Ave.</b>		d. STREET ADDRESS <b>19 E. Chesapeake Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>ELIZABETH</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1894</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. <b>64</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Princess Anne, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>John H. Packard</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Hardester</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Leroy Hinman--19 E. Chesapeake Ave.--</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x Tropic Myocarditis</b> DUE TO <b>Chronic Nephritis &amp; Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertensive Cardio-Vascular-Renal Disease &amp; Passive Congestion</b> (b) <b>Chronic Nephritis &amp; Uremia</b> (c) <b>Hypertensive Cardio-Vascular-Renal Disease &amp; Passive Congestion</b>		Crisfield, Md. INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>9 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, Virus Infection, Intestinal Toxin, Oct., 1957</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 23, 1958</b> to <b>May 31, 1958</b> , that I last saw the deceased alive on <b>May 29, 1958</b> , and that death occurred at <b>7:30 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>6/2/58</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 3, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 6 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Red Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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